

CLINICIAN'S TRAUMA UPDATE

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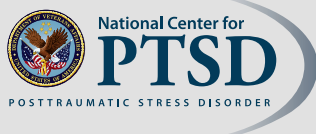
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TREATMENT

Randomized controlled trial evaluates CPT-C among active duty Servicemembers

Prior studies show that CPT-C, a version of Cognitive Processing Therapy that does not require patients to write about trauma details, can successfully treat PTSD in Veterans and non-Veterans (see [April 2008](#) and [June 2014 CTU-Online](#)). A recent randomized controlled trial led by investigators with the STRONG STAR Consortium is the first to show that CPT-C is also effective for active duty personnel. One-hundred and eight Servicemembers (100 men, 8 women) were randomized to 6 weeks of group CPT-C or group Present Centered Therapy (PCT). Each CPT-C and PCT group included 8-10 participants and met twice a week. Both treatments significantly improved PTSD, but CPT-C demonstrated several advantages. Relative to PCT, participants who received CPT-C showed larger drops on the PTSD Checklist ($d = -0.4$), but similar improvements on the PTSD Symptom Scale-Interview ($d = -0.2$). Gains on the Beck Depression Inventory-II favored the CPT-C group ($d = -0.3$); in fact, PCT did not seem to help with depression. Moreover, CPT-C participants attended fewer sessions ($M = 8.4$) than those who received PCT ($M = 9.8$). These findings support both the safety and efficacy of group CPT-C for active duty personnel, and add to growing evidence for this type of group therapy for PTSD.

Read the full article: <http://www.ptsd.va.gov/professional/articles/article-pdf/id43929.pdf>

Resick, P. A., Wachen, J. S., Mintz, J., Young-McCaughan, S., Roache, J. D., Borah, A. M., . . . Peterson, A. L. (& on behalf of the STRONG STAR Consortium) (2015). A randomized clinical trial of group Cognitive Processing Therapy compared with group Present-Centered Therapy for PTSD among active duty military personnel. *Journal of Consulting and Clinical Psychology*. Advance online publication. PILOTS ID: 43929

60-minute PE sessions may be as good as 90-minute

The standard format for Prolonged Exposure is a 90-minute session, which is not feasible within many practice settings. Investigators from Israel and the University of Pennsylvania have recently reported that PE with shorter sessions and less imaginal exposure is just as effective as the standard protocol. Participants were 39 Israeli Veterans with chronic PTSD. All participants attended two 90-minute sessions consisting of psychoeducation, trauma assessment, breathing retraining, and in-vivo exposure. Then, 19 participants were randomized to receive 90-minute sessions (with 40-minute imaginal exposures) and 20 were randomized to 60-minute sessions (with 20-minute imaginal exposures). The mean number of sessions was 13.3, with no difference between groups. The investigators used non-inferiority analysis to compare the effectiveness of the 60- and 90-minute sessions, using 7 points on the Posttraumatic Symptom Scale-Interview, 4.5 points on the Beck Depression Inventory, and 22 points on the Posttraumatic Cognitions Inventory as the non-inferiority margins. Results indicated that the short-duration group was non-inferior to the long-duration group at both posttreatment and 6-month follow-up, with both groups reporting significant improvement in PTSD, depression, and negative PTSD-related cognitions. Although short-duration PE resulted in less between-session habituation, lower amount of habituation was sufficient; more habituation did not translate into better outcomes. The study suggests that exposure sessions in PE can be significantly shortened without a decrease in efficacy, which may make PE easier to implement in more practice settings.

Nacasch, N., Huppert, J. D., Su, Y. J., Kivity, Y., Dinshteyn, Y., Yeh, R., & Foa, E. B. (2015). Are 60-minute Prolonged Exposure sessions with 20-minute imaginal exposure to traumatic memories sufficient to successfully treat PTSD? A randomized noninferiority clinical trial. *Behavior Therapy*, 46, 328-341. PILOTS ID: 43927

Patients prefer some PTSD treatments over others, but does preference matter?

Given the strength of the supporting research, policymakers and clinicians are increasingly promoting evidence-based PTSD treatments. But do patients see these as desirable interventions? Two recent studies investigate patient preferences for PTSD treatment and explore the potential benefits of matching patients to their preferred treatment.

In the first study, investigators at the Cincinnati VA interviewed 183 Veterans with PTSD to find out what they wanted for PTSD care. Upon referral to a VA PTSD clinic, Veterans attended a 1-session orientation group that described six psychotherapies (Prolonged Exposure, Cognitive Processing Therapy, Cognitive-Behavioral Conjoint Therapy, Virtual Reality Exposure Therapy, Nightmare Resolution Therapy, and Present Centered Therapy) and two types of medication (antidepressants and prazosin) for PTSD. Veterans then completed a survey about treatment preferences. Most Veterans (64.3%) preferred combined medication and psychotherapy; fewer wanted only psychotherapy (30.1%) or only medication (2.7%). Veterans interested in psychotherapy (with or without medication) were asked to rank the therapies in order of preference. CPT was most preferred (51.0%), followed by conjoint therapy (20.4%) and PE (18.5%). It is not clear whether aspects of the orientation influenced these preferences; for example, PE and CPT were always discussed first and Veterans watched videos about these two treatments only.

A second study led by investigators at the New York State Psychiatric Institute examined psychotherapy preferences among participants in a recent RCT (see the [April 2012 CTU-Online](#)). Prior to randomization, 110 participants read descriptions of PE, relaxation therapy, and interpersonal therapy (IPT) and rated their preference for or against each. Among the participants who expressed a preference for or against at least one treatment (79.1%), half preferred IPT (50.1%) while just over a quarter preferred either PE (26.4%) or relaxation therapy (26.4%). Although preferences against PE (26.4%) or relaxation (16.4%) were relatively uncommon, fewer participants were disinclined toward interpersonal therapy (2.7%). Participants without preferences had higher PTSD severity at baseline than participants with preferences, but showed the largest improvement after treatment. Participants who received an undesired treatment improved the least. When investigators examined the subsample of patients with comorbid depression, this pattern was even more dramatic. Patients with depression who received an undesired treatment had average posttreatment CAPS scores that were 43.4 points and 36.4 points higher than those without preferences or those matched to their preference, respectively.

Read the full article: <http://dx.doi.org/10.4088/JCP.14m09640>

These studies suggest that whether patients are choosing between medication and psychotherapy, or even choosing among different psychotherapies, patients do not see all treatments as equally attractive. In both studies, most participants preferred non-exposure interventions (CPT, IPT). How treatments are described, as well as the number and type of treatment options offered, may influence patient preferences. It is important for clinicians to provide complete and balanced information about treatment so patients can form educated preferences.

Take NOTE

New epidemiological review of PTSD, depression, and substance misuse in OEF/OIF Veterans

Investigators from the RAND Corporation summarize the research since 2009 on the prevalence of and risk factors for PTSD and related mental health issues among returning Veterans. Their review also covers the consequences of PTSD and mental health treatment use.

Read the full article: <http://dx.doi.org/10.1007/s11920-015-0575-z>

Ramchand, R., Rudavsky, R., Grant, S., Tanielian, T., & Jaycox, L. (2015). Prevalence of, risk factors for, and consequences of posttraumatic stress disorder and other mental health problems in military populations deployed to Iraq and Afghanistan. *Current Psychiatry Reports*, 17, 1-11. PILOTS ID: 43928

Assessing quality of care for PTSD and major depression

A separate report from RAND identifies potential quality measures of psychological health care within the military health system. Investigators describe the framework that guided their research and the candidate measures for PTSD and MDD care.

Read the full report: http://www.rand.org/pubs/research_reports/RR464.html

Hepner, K. A., Roth, C. P., Farris, C., Sloss, E. M., Martsof, G. R., Pincus, H. A., Watkins, K. E., Epley, C., Mandel, D., Hosek S. D., & Farmer, C. M. (2015). Measuring the quality of care for psychological health conditions in the military health system: Candidate quality measures for posttraumatic stress disorder and major depressive disorder (Report No. RR-464-OSD). Santa Monica, CA: RAND Corporation. PILOTS ID: 43814

Schumm, J. A., Walter, K. H., Bartone, A. S., & Chard, K. M. (2015). Veteran satisfaction and treatment preferences in response to a posttraumatic stress disorder specialty clinic orientation group. *Behaviour Research and Therapy*, 69, 75-82. PILOTS ID: 43930

Markowitz, J. C., Meehan, K. B., Petkova, E., Zhao, Y., Van Meter, P. E., Neria, Y., . . . Nazia, Y. (2015). Treatment preferences of psychotherapy patients with chronic PTSD. *Journal of Clinical Psychiatry*. Advance online publication. PILOTS ID: 43926

Web-based PTSD intervention promising for Veterans who stick with it

Online self-help interventions for PTSD may benefit Veterans who do not want in-person therapy. Investigators from the Washington DC VA and National Center for PTSD examined the feasibility and potential benefits of one such intervention for OEF/OIF Veterans. Participants were returning Veterans referred to a VA PTSD specialty clinic; 13 met PTSD diagnostic criteria but chose not to engage in treatment and 11 failed to meet diagnostic criteria and were ineligible for clinic services. Care managers introduced participants to the online cognitive-behavioral self-management intervention, the Posttraumatic Stress (PTS) Workshop from afterdeployment.org, and instructed them to complete one of

the 8 modules each week. The PTS Workshop includes psychoeducation, identification of trauma cues, relaxation and breathing exercises, problem-solving skills, and trauma writing exercises. Care managers called participants weekly for brief assessments and to encourage workshop use; total call time per treatment completer was only about an hour. On average, participants completed 4.5 modules. Investigators only examined symptom change for 10 treatment completers, who finished 5 or more modules and had post-treatment data. Completers had large improvements in PTSD ($d = 1.04$). Ratings of overall treatment satisfaction, convenience, and usefulness were positive. Drawing conclusions from this study is limited by the focus on treatment completers, especially in light of the high dropout (58%). The results are important, however, because they demonstrate the need for strategies to enhance engagement in self-help if used as an alternative to in-person therapy.

Read the full article: <http://www.ptsd.va.gov/professional/articles/article-pdf/id43596.pdf>

Belsher, B. E., Kuhn, E., Maron, D., Prins, A., Cueva, D., Fast, E., & France, D. (2015). A preliminary study of an internet-based intervention for OEF/OIF Veterans presenting for VA specialty PTSD care. *Journal of Traumatic Stress*, 28, 153-156. PILOTS ID: 43596

COMORBIDITY

Comorbid depression does not compromise effectiveness of trauma-focused therapy

Some studies suggest that comorbid depression decreases treatment completion or treatment response in trauma-focused psychotherapy for PTSD, but others have found no relationship. Investigators from the Cincinnati VA revisited this issue in a recent study. Participants were 757 male and female Veterans who received outpatient Cognitive Processing Therapy between 2005 and 2013. For analyses, investigators grouped participants according to the severity of their pretreatment depressive symptoms based on recommended cutoffs on the Beck Depression Inventory-II. Over half of the sample (58.9%) reported symptoms consistent with severe depression. Treatment dropout and clinically significant improvement, defined as a drop of at least 10 points on the PTSD Checklist, did not differ across groups. Dropout ranged from 40.4% to 41.7% and the proportion of participants in each group who made clinically significant gains ranged from 36.6% to 46.0%. These findings indicate that severity of depressive symptoms is not a key factor in predicting who will complete or respond to CPT—and that patients with severe depression can still benefit from trauma-focused therapy. Although the investigators did not report on changes in depressive symptoms, they suggest that similarities between CPT techniques and those used in evidence-based treatments for depression may explain CPT's effectiveness in this comorbid population.

Read the full article: <http://dx.doi.org/10.1037/tra0000034>

Hemmy Asamsama, O., Dickstein, B. D., & Chard, K. M. (2015). Do scores on the Beck Depression Inventory-II predict outcome in Cognitive Processing Therapy? *Psychological Trauma: Theory, Research, Practice, and Policy*. Advance online publication. PILOTS ID: 43925

Benefits of CPT similar for military sexual trauma and other trauma types

Military sexual trauma affects both men and women and may lead to more severe PTSD symptoms than other trauma types. Investigators from the Cincinnati VA examined whether male and female Veterans who identify MST as their index, or worst, trauma respond differently to CPT than Veterans with other index traumas. The investigators reviewed the treatment records of Veterans with full or subthreshold PTSD who received CPT as part of a 7-week residential program and compared outcomes of male Veterans with MST index trauma to their female counterparts and to those with other index traumas (like combat or childhood abuse). Of the 481 Veterans in the study, 40.7% identified MST as their index trauma (24.5% of men, 62.0% of women). Compared with the non-MST group, the MST group had more severe clinician-rated PTSD symptoms, but similar levels of self-reported PTSD symptoms at baseline. Although in general women showed greater improvement in PTSD symptoms than men, Veterans with and without an MST index trauma showed similar improvements after CPT. These results suggest that CPT effectively treats PTSD symptoms in both men and women who identify MST as their worst trauma. It is important to note that Veterans in this study received a number of interventions in addition to CPT during residential treatment; it is not known whether these results would generalize to outpatient settings where Veterans receive weekly CPT sessions.

Read the full article: <http://dx.doi.org/10.1002/jts.22006>

Voelkel, E., Pukay-Martin, N. D., Walter, K. H., & Chard, K. M. (2015). Effectiveness of Cognitive Processing Therapy for male and female U.S. Veterans with and without military sexual trauma. *Journal of Traumatic Stress*, 28, 174-182. PILOTS ID: 43931

A couples-based integrated treatment for PTSD and AUD

Research on integrated treatments for Veterans with co-occurring PTSD and alcohol use disorder (AUD) has focused on individual or group therapy. New findings from a team led by investigators from the Cincinnati VA suggest that a couples format combining two validated treatments, behavioral couples therapy for AUD and cognitive-behavioral conjoint therapy for PTSD, is promising. Of 12 male Veterans with PTSD and AUD and their female partners who entered the study, 9 initiated treatment and 7 completed 12 or more of the 15 treatment sessions. Clinician-, Veteran-, and partner-reported PTSD improved from before to after treatment (d s = 0.94, 1.22, 1.70, respectively). Five Veterans had clinically reliable improvement on both the CAPS and PCL. Six Veterans had a reliable decrease in percent days of heavy drinking (d = 1.01). Depression also decreased among Veterans

(d = 0.93) and partners (d = 1.06). The investigators noted that the two treatment protocols integrated well, although the behavioral couples therapy content was revised to align with low-risk drinking and harm reduction goals because most Veterans were unwilling to pursue alcohol abstinence. The study suggests feasibility and preliminary efficacy of an approach for addressing a difficult to treat comorbidity among Veterans, and for improving partner depression. Future research should include follow-up assessments to ascertain if benefits are maintained beyond the treatment phase.

Read the full article: <http://dx.doi.org/10.1002/jts.22007>

Schumm, J. A., Monson, C. M., O'Farrell, T. J., Gustin, N. G., & Chard, K. M. (2015). Couple treatment for alcohol use disorder and posttraumatic stress disorder: Pilot results from U.S. military Veterans and their partners. *Journal of Traumatic Stress, 28*, 247-252. PILOTS ID: 43932



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